Arizona Department of Health Services Division of Behavioral Health Services

Summary of Input from Behavioral Health Providers Regarding Coordination of Care

March 2012

Background Information

On March 7, 2012, the Arizona Department of Health/Division of Behavioral Health solicited input from providers who serve individuals with general mental health (GMH), substance abuse (SA), or children regarding care coordination of services. Care coordination is frequently described as the process by which members are linked to social supports and medical services, breaking down the boundaries between systems of care, assisting members and families, and facilitating communication between all parties involved in the care of the individual.

Participants

Forty-one (41) providers participated in the forum. The provider forum was held at ADHS's meeting facility (Room 215 A and 215B) from 3:00 – 5:00 pm. Seven (7) questions were posed; the participants were divided into 8 groups, each group assigned to answer one particular question, and then subsequently answering the remaining questions. Groups 1 & 8 were assigned Question 1. Five providers were on conference call for additional input.

Executive Summary

- Providers were in agreement that coordination of care for children is a much more robust process than that of the adult population.
- Communication between behavioral health providers and primary care physicians is generally fragmented when it comes to care coordination. An integrated grand rounds communication approach would help the process for care coordination.
- Most providers practice the team approach to coordination of care but some were concerned with the inconsistency of the process.
- There is a systems issue and cost associated with care coordination that BH and PCP providers bear when it comes to care coordination. Technology has failed at bridging systems so that an overall picture of a patient's diagnoses is assessed.
- The team approach to deliver coordination of care is practiced by most providers including case managers, peer support, CPS, family members, state agencies, provider agencies, psychiatrists, treatment coordinators, etc.
- Some providers cautioned that too many people (3 vs. 18 people) involved in the care coordination process could be inefficient for the decisions that need to be made.
- Providers expressed that both behavioral health and primary care providers do not have the financing available to accommodate a large decision-pool of people – A combined expense might lead to loss of revenue.
- Most providers were in agreement that some type of incentive process needs to be put in place for the care coordination process.
- Providers expressed that education is an area of improvement so that the workforce is better equipped to work through care coordination and agreed that behavioral health training in universities and schools are lacking thereby creating a system that does not promote culture change and vice versa for the primary care providers.
- Providers in general, agreed that lack of shared electronic records through the entire care coordination process hinders the system of care.

- During the session providers expressed the following concerns:
    - AHCCCS and DBHS policies are limiting.
    - The volume of work for both sides (behavioral and acute care) is overwhelming due to lack of resources.
    - Lack of ongoing relationship with the PCP; that is auto-assigned and generates negative responses from all who are involved in care coordination.
- Many providers were in favor of statewide health information exchange in order to improve care coordination for their members.
- Others expressed education as another area of improvement so that the workforce is better equipped to work through care coordination.
- Some providers believe that
    - all acute health care data would help care coordination
    - although data is important, there is a need to educate professionals in how to translate and use the data being provided
    - having primary care providers in attendance at forums aides in the communication and shared concerns over care coordination
- A direct feed from AHCCCS would aide in the care coordination process.
- Including social supports would improve relationships with non-behavioral health providers to advance care coordination while others expressed the need to build relationships with associations and use technology to provide better care coordination.
- Some providers see the need for better cultural exchange by aligning roles and finances in improving relationships for both provider communities.
- Providers described how well they work with the limited resources (highlighted GMH/SA providers)..
- Providers also highlighted Children's services as doing a good job of implementing system of care on every level.
- Providers would like to continue to pursue person-centered-treatment.

Below are the answers received from the providers. Answers are listed as received from each of the groups' notes with minor editing for clarification and readability; they reflect the voice of the providers participating.

Provider's Current Care Coordination Efforts, Barriers to Care Coordination

- Several groups believe that when it came to children's care coordination, the process was robust while others believe that both children and adult care coordination was spotty, one-sided, inconsistent, and minimal at best.
- Means currently used to coordinate care by most providers include:
    - FAX/Electronic reporting
    - Working with all stakeholders
    - In the adult system: use of JPO, PCP, CPS, family, church, CPS
    - In the children system: use of CPS, JPO, PCP, DDD, schools, family
    - Psychiatric services
    - Health risk assessments for adults with AXIS III diagnoses
    - Case management services ie. Doctor's appointments, child and family team meetings
    - Care Coordinators attending inpatient staff meetings, discharges, and ongoing planning to deter future hospitalizations

- Most providers use a team approach to coordinate care for members; however some stated that due to volume, the team approach was not possible due to limited resources and competing priorities (e.g. addressing immediate needs vs. clinical acuity)
- Providers listed the following as **barriers** to coordination of care/services with the acute health care system,
    - Inconsistent follow-up and/or non-existent follow-up of members and their progress
    - PCP and BH provider are not distinct in the process
    - Technology systems unable to "talk" to each other – Lack of shared electronic records, claims data, codes not aligned, etc.
    - Case-by-case scenario makes it difficult to gather information
    - Fallacy about PCP's assigned in AHCCCS is non-existent
    - Unable to find out information regarding chronic diseases and lab diagnostics
    - Occasionally, the PCP is not part of the team
    - No incentives for providers across both sides of the system
    - Culture change – Integration affects culture change when integrating services and should be addressed in schools, universities and current medical staff
    - Philosophical differences in how and what to share
    - Lack of care management
    - Difficulty building relationships for both BH and PCP providers
    - Policy is not aligned
    - Existing staff not well versed/trained in current processes or future changes
    - Resources - Volume of work on both sides of the system is overloaded
    - Member's do not have a relationship with their PCP – Auto-assigned a PCP
    - Level of funding is inadequate
    - Family members not always included in the hospital discharge process

Improving Care Coordination

- Suggestions to help better coordinate care include:
    - Integrated electronic medical record including statewide health information exchange
    - Legible writing
    - Use of technology – Cell phones, tables, laptops to convey information
    - Incentivizing physicians – Align incentives; blended payments and fee schedules, integrated CPTs
    - Administrative rules allow for an integrated practice in its licensing and credentialing standards
    - Elimination of stigma
    - IT systems "talk" to each other
    - Basic needs are met – Transportation, housing, food, and employment
    - Need to be open to a matrix model:
        - Virtual integration
        - Co-location
        - Full integration
    - Better education for behavioral and physical providers' staff
    - Better job of transforming from adolescent services to GMH
    - Direct eligibility feed from AHCCCS
    - Common language between providers/stakeholders

- Peer support
- Consider alternative care solutions in wellness like yoga, use of telemedicine, etc.

- Providers suggested that **relationships with non-behavioral health providers could be improved by:**
  - Including of social supports, PCPs, use of technology and apps to help bridge the gap between child and adults, development of school-based clinics, use of natural community sites (e.g. malls, schools, hospitals, fire departments, colleges, communities of faith, and universities)
  - Identifying cultural leaders who impact social supports as well as the healthcare system, build relationships with associations
  - Becoming educated in order to understand
  - Sensitivity training
  - Broader scope of stakeholder base
  - Developing skill-set definitions (e.g. Medical terminology for behavioral staff and vice-versa for provider staff)
  - Aligning of financial incentives
  - Aligning of EMHR with integrated HIE
  - Allowing for pilot projects regarding integration of care

Data & Training

- Types of data that providers would like to have in the future include:
  - Overall utilization – PCP information, visits, hospitalizations, current medical diagnoses, neurological test results, medication, medical history AXIS I-X information, allergies/adverse reactions, chronic condition, pharmacological data, disease management data, lab results, etc.
  - Comparative data of population as a whole in order to ID outliers
  - EMHR have critical elements and flags
  - A system to identify conflicts between PH and BH so that both parties can focus on the most immediate needs of care
  - Wellness markers
  - Person-Centered-Care – What data does the service recipient need so they can make decisions about informed care
  - Learn from disability communities (like the Deaf and Blind communities) on how to disseminate data
  - Inform family and natural supports regarding what to do with the data
  - Understand what the indicators mean in order to know what the patient needs
- Types of training on data utilization for making decisions regarding coordination of care include:
  - Joint training regarding physical and behavioral health information like understanding discharge summary, notes, treatment planning, etc.
  - How to access information from a shared medical portal
  - Integration of roles
  - Integrated forums/meetings
  - Education of current and future staff about PH/BH processes – Joint training opportunities regarding integrated care
  - Education in schools and universities about integrated care

Working Well in Current System (Maricopa County)

In the children system:

- Current service array
- The 12 Principles
- Family movement (examples mentioned were MIKID and FIC)

In the adult system:

- The 9 Principles
- Peer and family training

Providers also mentioned the following:

- 1st responder/early identification
- Effective assessment and triage, no wrong door
- MMWIA, DSP's richness of children's system in terms of staffing
- Specialty services have been developed – 0-5, SO, SA
- Recovery focus
- MMWIA
- Transition of services (no information was provided if this referred to both, or only the children or adult system)
- Development of HNCM in SOCPR
- GMH/SA-Dedicated recovery coach
- Partnership between behavioral health providers-sharing of resources
- Peer-run partnerships
- Flex funds
- Direct support on children's side
- Peer support on adult side
- Emphasis on person-centered treatment – We need to keep pursuing, further to reach
- Crisis system works
- Provider system works well
- Innovation – We have stability
    - GMH/SA-Wide array of services
    - Children
        - CFT Design change
        - Change in assessment tool requirement
        - Intensive case management
        - GMH/SA providers overall are incredibly good at doing well with limited resources. Willingness to share information with population served and as a whole system.
- GMH/SA providers do a really good job at being solution-focused, work well to address and resolve recurring problems.
- On the children's side, providers urged to retain support services (CMS level, psychosocial services); you won't have a system of care if you don't have case management services; may need those services intermittently.
- Go to a medical model and retain those types of services for adult and children. Flex fund is valuable as well as peer support and transition services.
- Treat young adults as their own population. When the 12 principles were created, the 9 principles on the adult side needed to be added.
- Support of cultural competency should not change.
- Recommend expanding codes to include more wellness codes.

Arizona Department of Health Services, Division of Behavioral Health Services

Questions for Non-SMI Provider Forum, March 7, 2012

These questions apply to providers who serve individuals with general mental health (GMH) issues, substance abuse (SA) issues, or children.

Care coordination is frequently described as the process by which members are linked to social supports and medical services, breaking down boundaries between systems of care, assisting members and families, and facilitating communication between all parties involved in the care of an individual.

1) How do you coordinate care for your members in your practice (i.e. PCP visits, chronic disease management, hospital discharges, etc)?

2) Do you use a team approach to coordinate care for your members? If so, whom do you include on the team?

3) What barriers do you encounter that affect your ability to coordinate care/services with the physical health system?

4) What can help you better coordinate care for your members?

5) How can you improve your relationships with non-behavioral health providers to better coordinate care? What new relationships would be helpful to you?

6) There may be acute health care data made available to you in the future. What data would best help you coordinate care? What type of training do you think you will need to properly utilize this data in making decisions for care coordination?

7) Describe what is currently working well in the existing BH delivery system for the GMH/SA population and the children's system of care that you would like to preserve in the next Maricopa County RBHA contract.

For more information and to provide additional feedback about integrating behavioral and physical health care in Maricopa County, visit http://www.azdhs.gov/diro/integrated/index.htm and use the "Contact Us" form located in the homepage.